INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT AGENTS FOR CYSTIC FIBROSIS PRIOR AUTHORIZATION (PA) REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: 866-930-0019

CareSource Rxinnovations

Today's Date ☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Member's CareSource ID	Member's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Member's Name	Prescriber's Name
Prescriber's Indiana License Number	Specialty
Prescriber's National Provider Identifier	Office Contact
Prescriber Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber Address	Date(s) of Service Start Date
Diagnosis	Diagnosis Code

Requested Medication	Strength	Directions for Use	Quantity

Note: Please submit copy of genetic testing performed for any of the medications being requested below.

PA Requirements for Kalydeco (ivacaftor):

Member weight: _____ (specify lbs or kg)

Member is 1 month of age or older? □ Yes □ No

Diagnosis of cystic fibrosis with one mutation in the CFTR gene that is responsive to ivacaftor? □ Yes □ No

Member is NOT homozygous for F508del mutation in the CFTR gene? □ Yes □ No

Note: Members with hepatic impairment may require dose and/or frequency adjustment.

PA Requirements for Orkambi (lumacaftor/ivacaftor):

Member weight: _____ (specify lbs or kg)

Member is 1 year of age or older? □ Yes □ No

Diagnosis of cystic fibrosis with a homozygous F508del mutation of the CFTR gene? □ Yes □ No

Note: Members with hepatic impairment may require dose and/or frequency adjustment.

PA Requirements for Symdeko (tezacaftor/ivacaftor):

Member weight: _____ (specify lbs or kg)

Member is 6 years of age or older? □ Yes □ No

Please select one of the following:

- □ Diagnosis of cystic fibrosis with a homozygous F508del mutation in the CFTR gene
- □ Diagnosis of cystic fibrosis with at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor

Note: Members with hepatic impairment may require dose and/or frequency adjustment.

PA Requirements for Trikafta (elexacaftor/tezacaftor/ivacaftor):

Member weight: _____ (specify lbs or kg)

Member is 2 years of age or older? □ Yes □ No

Please select one of the following:

- □ Diagnosis of cystic fibrosis with at least one F508del mutation in the CFTR gene
- □ Diagnosis of cystic fibrosis with at least one mutation in the CFTR gene that is responsive to elexacaftor/tezacaftor/ivacaftor based on in vitro data

Note: Members with hepatic impairment may require dose and/or frequency adjustment.

I attest that the information provided above is accurate:

Physician Signature: _____ **Date:** _____